ARC 3549C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 12(15)(c), the Department of Human Services amends Chapter 74, "Iowa Health and Wellness Plan," Chapter 75, "Conditions of Eligibility," and Chapter 76, "Enrollment and Reenrollment," Iowa Administrative Code.

These amendments eliminate the three-month retroactive Medicaid coverage benefit provisions for initial applications and applications to add new household members. Pursuant to 2017 Iowa Acts, House File 653, as passed during the 87th Session of the General Assembly, the Department requested a waiver from the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services to eliminate the retroactivity provisions. Upon federal approval, elimination of three-month retroactive eligibility for Medicaid applicants began on November 1, 2017.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 3355C** on October 11, 2017. The proposed amendments were also Adopted and Filed Emergency and published as **ARC 3353C** on the same date and became effective October 1, 2017.

The Department received comments from four respondents during the public comment period. A summary of the respondents' comments and the Department's responses is as follows:

Comment 1: Two respondents expressed vehement opposition to the emergency rules. All respondents requested that the Department suspend or delay implementation of the policy to eliminate retroactive Medicaid. Three respondents requested a delay until after the 2018 Legislative Session, and a fourth respondent requested a delay until after the Department has determined the true impact of the policy and explored exceptions to policy for patient populations receiving care at Iowa's hospitals. One respondent requested that the rules be modified to allow retroactive Medicaid for patients who face an unexpected and undue hardship and are truly prevented from applying for Medicaid within the three-month time period.

Department response 1: The Department needs legislative authority and CMS approval to suspend or delay implementation of the policy to eliminate retroactive Medicaid or to make an exception for a specific population, except as authorized by CMS for pregnant women and infants (see Department response 2).

Comment 2: Three respondents stated that they were aware of the provision to eliminate retroactive Medicaid included in House File 653 but believed that the provision to eliminate retroactive Medicaid applied only to the Medicaid expansion population.

Department response 2: Conversations with all providers and advocacy groups occurred with as much transparency as possible as the legislation was developing.

The provision in House File 653 related to elimination of retroactive coverage does not specify populations, such as the Medicaid expansion population. The legislation mandates that the Department seek a waiver from CMS to implement the strategy to eliminate retroactive coverage for Medicaid applicants.

Iowa Medicaid Enterprise sent an Informational Letter (1808-MC-FFS-D) to all Medicaid providers on June 30, 2017. The letter explained that House File 653 contained a number of legislatively mandated cost-containment initiatives and specified that one such initiative was to eliminate retroactive benefits for all Iowa Medicaid eligibility groups.

In accordance with the legislative mandate in House File 653, the Department filed for a waiver to eliminate retroactive benefits for all Iowa Medicaid eligibility groups. CMS approved the waiver to eliminate the three-month retroactive period for all Medicaid applicants with the exception that Iowa must continue to provide three months of retroactive Medicaid to pregnant women and infants (under the age of one) who otherwise qualify.

In the Adopted and Filed Emergency rule making, the amendments revised, renumbered or amended the rules to remove the retroactive benefit for Medicaid for all populations. After publication of the

Adopted and Filed Emergency rule making, CMS instructed the Department to reinstate retroactive Medicaid benefits for pregnant women and infants (under the age of one). Therefore, the amendments in this rule making reinstate retroactive Medicaid eligibility for pregnant women and infants (under the age of one).

Comment 3: All respondents expressed concerns regarding the populations that their organizations serve and the ability of their organizations to continue to serve Medicaid patients. Specifically, respondents' comments are as follows:

• **Elderly and disabled persons needing postacute and chronic care:** The Department included its rationale for this amendment request which is founded on the fact that the commercial market does not allow for retroactive coverage. However, Medicaid is the payor for an entirely separate and unique population than the commercial market. Many aged and disabled will be left without coverage even though they meet the eligibility requirements.

This change will have a large impact on the amount of money seniors or their families pay for a hospital stay, residence in a skilled nursing facility, etc. For many aging individuals, the need for nursing facility care can come on suddenly. For example, a fall may result in a broken hip from which a frail senior may never fully recover. A sudden need does not allow for preplanning. Retroactive Medicaid coverage would allow a window of opportunity to get one's Medicaid coverage in order. With nursing home care costing $5,000 to $8,000/month, a 90-day bill can run $15,000 to $25,000. If a senior in such a situation is determined Medicaid-eligible in the application month, the senior is not in the financial situation to be able pay for the health care services received prior to the application month, creating a significant financial hardship for the senior and increased uncompensated care costs for the provider.

If this rule advances, Iowa health care system members will have to carefully consider whether they can continue to admit Medicaid-eligible Iowans into their nursing facilities.

• **Persons with catastrophic injuries and traumatic brain injuries:** Special consideration should be made for those individuals who experience a catastrophic injury or event such as a traumatic brain injury or stroke. For these individuals and their families, eliminating the retroactive period would be devastating. Survivors of catastrophic injury are first and foremost focused on survival, and then on rehabilitation. Such individuals are now unable to work, are likely to lose their jobs, and must apply for social security disability, which takes six months for approval. With no job and no income, many will lose their insurance and be at high risk of having a gap in health coverage. Nevertheless, they have to be treated.

Persons with catastrophic injury may not be able to apply for Medicaid on their own and may not have a legal representative to assist. This would lead to gaps in health coverage if there is no retroactive Medicaid period.

This organization has served persons whose insurance premiums were not paid while they were in acute care settings. Insurance may lapse retroactively, and the lapse may not be discovered immediately. Again, without retroactive Medicaid benefits, there would be a lapse in coverage. Currently, if an injured individual misses a deadline in providing information to the Department, the Medicaid application is closed and a new application has to be started. This is often the case when essential documents, such as 401(k) statements, are not able to be secured on Medicaid's timeline. Again, this would cause a lapse in coverage for the individual if there are not retroactive Medicaid benefits.

• **Patients receiving hospital care, including emergency care:** The rule change will bring extreme financial strain and liability on Medicaid beneficiaries for their cost of care prior to enrollment. Medicaid patients often have significant financial needs; therefore, this rule will place an additional financial burden on hospitals and safety-net providers and will reduce their ability to serve Medicaid patients.

Hospitals are already struggling to cope with Medicaid changes and additional cost-containment strategies implemented in the last Legislative Session. Hospitals are seeing an increase in administrative expense, increased difficulty finding long-term placement options and an increase in charity care and bad debt that affects the financial stability of Iowa's hospitals, especially in rural communities.

Iowa's hospitals care for all patients in need of emergency care, at all hours of the day, regardless of ability to pay and cannot deny emergency services to those without an insurance card. Hospitals are required by federal law to provide emergency care. The Iowa Hospital Association's members have

expressed concern regarding the financial liability of Medicaid eligible patients, whether behavioral health patients whose illness impacts their ability to move forward with a Medicaid application or a trauma patient who has lost the ability to communicate and needs additional time to work through the application process. While these cases may not happen every day, when they do, these are cases of a high level of care at extraordinary expense. Iowa's hospitals will no longer be able to rely on retroactive enrollment to ensure payment for care in these situations. The results of this policy decision are possibly catastrophic to these patients and the hospitals that assist them.

• **Persons with behavioral health needs (substance use disorders/addictions, mental health):** Patients who qualify for Medicaid, in addition to having significant financial needs, also commonly have behavioral health needs. Their needs prevent them from being able to fully comprehend the need for and timelines to apply for coverage. Additionally, the Department's rationale for the change is to align Medicaid more closely with the commercial insurance market, but Medicaid is the payor for an entirely separate and unique population than the commercial market. This shift will remove an important safety net and directly shifts the financial burden to providers and medical facilities and ultimately reduces their ability to serve Medicaid patients.

Department response 3: The Department needs legislative authority and CMS approval to make an exception and continue to allow the three-month retroactive period for a specific population, except as authorized by CMS for pregnant women and infants (see Department response 2).

There are other ways an applicant can get Medicaid coverage retrospectively without applying the three-month retroactive period:

• Eligibility for applicants who are determined eligible for Medicaid will continue to be effective as of the first of the month of application, regardless of when the decision is made. For example, if an application is filed on December 29 and in March, the Department determines that the applicant is Medicaid-eligible for the months of December through March and ongoing, Medicaid is approved effective December 1. Any unpaid medical bills incurred on or after December 1 will be covered as long as the service is a Medicaid-covered service.

• The 90-day reconsideration period allows a former Medicaid member to submit a Medicaid review up to 90 days past the expiration of the member's 12-month eligibility period without needing to submit a new application. If the person is determined eligible, the effective date of the new eligibility period goes back to the first of the month after the previous eligibility period ended and there is no lapse in coverage.

Comment 4: If facilities become hesitant to admit individuals who have suffered a catastrophic injury since there would no longer be "presumptive Medicaid," individuals would be forced to stay in the hospital and acute care settings until their Medicaid was active and verified or until they receive approval for disability, which takes six months to determine. Acute hospital stays are considerably more expensive than the next level of service.

Department response 4: These rule changes do not impact presumptive Medicaid. Hospitals and other providers that are designated as a "presumptive provider organization" can make a presumptive Medicaid eligibility determination for persons seeking services. "Presumptive Medicaid" is available to applicants who are children, pregnant women, parents and caretakers, persons aged 19 to under age 65, persons in need of treatment for breast or cervical cancer, and certain former foster care children.

If the provider determines an applicant eligible for presumptive Medicaid, eligibility begins as of the date the presumptive provider makes the eligibility determination and enters the data into the Department's system. Presumptive Medicaid eligibility continues until the last day of the month following the month of the presumptive determination or until the Department makes a formal Medicaid decision, whichever occurs earlier.

Comment 5: Without the retroactive period, there will likely be more individuals forced to stay in acute care until Medicaid coverage can be verified instead of transitioning to a lower level of care. This will result in significantly higher costs and less effective care. Additionally, because of the process of applying for Medicaid, there will be a lapse between private insurance and Medicaid benefits in many cases. This could result in:

• Uninsured individuals with medically complex situations who have nowhere to turn for treatment, which is putting extreme undue hardships on the individuals and their families.

• Limited admissions to rehabilitation providers who are unable to take on the risk of uninsured individuals without the retroactive coverage.

• Delaying individuals the right to crucial rehabilitation at the time that recovery and successful outcomes are most likely.

Department response 5: The Department needs legislative authority and CMS approval to make an exception and continue to allow the three-month retroactive period for a specific population, except as authorized by CMS for pregnant women and infants (see Department response 2).

The Department believes many in this situation may be eligible under presumptive Medicaid and eligible for retroactive benefits as of the first of the month of application (see Department responses 3 and 4).

Comment 6: Iowa will be the first state in the nation to eliminate retroactive coverage for the traditional Medicaid population (non-expansion population, including the disabled).

Another respondent commented similarly saying "no other state is advancing this type of cost-shift to private-pay residents."

Department response 6: The Department proposed these amendments to align Medicaid policy with that of the commercial market, which does not allow for an individual to apply for retroactive insurance coverage.

The Department needs legislative authority and CMS approval to suspend or delay implementation of the policy to eliminate retroactive Medicaid or to make an exception and allow the three-month retroactive period for a specific population, except as authorized by CMS for pregnant women and infants (see Department response 2).

Comment 7: With a lack of consistent reporting from the Iowa jails to Iowa Medicaid Enterprise, it is often impossible to know if a Medicaid patient has lost coverage due to being incarcerated for over 30 days. Providers rely upon the state's eligibility line for verification, and unfortunately, it is not real time. Thus, treatment is provided based upon inaccurate eligibility data, and in the end, the provider is stuck with the cost and repayment of any funds received for this service.

Department response 7: The Department acknowledges this comment and that there are issues with the Department's receipt of timely and accurate incarceration data. However, the Department does not see this issue as relevant to the elimination of the three-month retroactive period.

Comment 8: All the respondents expressed concerns about costs shifting to providers and Medicaid members, and some respondents believe that the Department underestimated the fiscal impact of the rule change.

Department response 8: There continues to be strong opposition to and disagreement with the Department's assessment of the overall fiscal impact of these amendments and the impact as it relates to the long-term care data.

The Department received an approval from CMS to implement elimination of retroactive coverage strategy for all Medicaid applicants, except for pregnant women and infants under the age of one, and as a result, the Department recalculated the fiscal impact to exclude the two populations:

- Total annual Medicaid savings = $26,956,724. Reduced from $37,086,260.
- Annual State savings = $5,586,234. Reduced from $9,835,575.
- Savings for the following eligibility groups remain unchanged from the September calculations:
  - Elderly: Total = $262,791; State = $110,241
  - Disabled: Total = $4,368,799; State = $1,832,711
  - Long-term care facility: Total = $334,478; State = $140,314

As previously stated, there are other ways for an applicant to obtain Medicaid coverage retrospectively without application of the three-month retroactive period (see Department response 3). The Department thinks there may be a misunderstanding of the situations that actually meet the criteria of the three-month retroactive coverage as opposed to retroactive benefits applied for other reasons. The Department is

willing to meet with the providers individually to discuss the situations that meet the definition of the three-month retroactive period in order to understand the discrepancies.

As explained in Department response 2, these adopted amendments have been changed from those published under Notice of Intended Action and Adopted and Filed Emergency to reinstate retroactive eligibility for pregnant women and infants (under the age of one).

The Council on Human Services adopted these amendments on December 13, 2017.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, it was determined that Medicaid providers may experience financial loss due to nonpayment of unpaid medical bills incurred in the three months prior to a Medicaid applicant's filing of an application.

These amendments are intended to implement Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 12(15)(a)(7).

These amendments will become effective February 7, 2018.

The following amendments are adopted.

ITEM 1. Adopt the following **new** subrule 74.5(4):

74.5(4) *Retroactive enrollment.* Medical assistance shall be available to a pregnant woman or an infant (under one year of age) for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—subrule 76.13(3).

ITEM 2. Adopt the following **new** subparagraph **75.1(35)"d"(5)**:

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

ITEM 3. Amend paragraph **75.1(35)"e"** as follows:

e. Medically needy income level (MNIL).

(1) and (2) No change.

(3) The MNIL for the certification period shall be determined by adding both months' MNIL to arrive at a total. The MNIL for the retroactive certification period, when applicable, shall be determined by adding each month of the retroactive period to arrive at a total.

(4) No change.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period when applicable shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

ITEM 4. Amend subparagraph **75.1(35)"g"(1)** as follows:

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3," paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

ITEM 5. Adopt the following **new** subparagraph **75.11(2)"c"(3)**:

(3) Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph 75.11(2)*"d," "e,"* or *"i."* The

retroactive months are outside the "reasonable period" during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

ITEM 6. Adopt the following **new** paragraph **75.19(1)"e"**:

e. Children who are eligible only in a retroactive month.

ITEM 7. Amend rule **441—75.25(249A)**, definition of "Incurred medical expenses," as follows:

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or the certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

ITEM 8. Adopt the following **new** definitions of "Retroactive certification period" and "Retroactive period" in rule **441—75.25(249A)**:

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

ITEM 9. Adopt the following **new** subrule 76.4(6):

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child's food assistance effective date when the child was an infant (under the age of one) during any of the three months and the child:

a. Has medical bills for covered services that were received in that period; and

b. Would have been eligible for medical assistance benefits in the month services were received if the application for medical assistance had been made in that month and the eligibility determination was made without regard to food assistance eligibility.

ITEM 10. Adopt the following **new** subrule 76.13(3):

76.13(3) *Retroactive enrollment.*

a. Except as provided in paragraph 76.13(3)*"e,"* medical assistance shall be available for all or any of the three months preceding the month in which an application is filed to a person who was pregnant or an infant (under the age of one) during any of the three months and who:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance shall be made available when an application has been made on behalf of a deceased person who was an infant or was pregnant if the conditions in paragraph 76.13(3)*"a"* are met.

d. Persons enrolled in Medicaid based on receipt of supplemental security income benefits who wish to make application for Medicaid benefits for the three months preceding the month of application shall complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship or alien status has not been verified even though they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

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